

C209A

LONG ISLAND JEWISH MEDICAL CENTER
RECORD OF OPERATION

SURGEON: VINCENT PARNELL, M.D. PITAMBAR, AVINASH
1ST Assistant: DOMINICK DECAPUA, M.D. 1889291
09/13/04

ANESTHESIA: GENERAL ENDOTRACHEAL. BY DR. MICHAEL MEYERS.

PREOPERATIVE DIAGNOSIS: VALVAR AND SUPRAVALVAR PULMONARY
STENOSIS.

OPERATION: RELEASE OF RIGHT VENTRICULAR OUTFLOW TRACT
OBSTRUCTION BY TRANSANNULAR PATCHING OF VALVAR
AND SUPRAVALVAR PULMONARY STENOSIS.

POSTOPERATIVE DIAGNOSIS: SAME.

PROCEDURE: On the date mentioned above, the patient was brought into the operating room and placed on the operating room table in the supine position after the induction of general endotracheal anesthesia. With full hemodynamic monitoring, the patient was prepped and draped using the usual sterile technique. A median sternotomy incision was made and was carried down to the skin and subcutaneous tissue. The sternum was divided using the saw. The pericardium was opened, T'd and suspended and a small amount was harvested to be used as a patch. The patient was systemically Heparinized and the ascending aorta was cannulated using the Bio-Medicus arterial profusion cannula. A single venous cannula was placed low in the right atrium and the patient was placed on cardiopulmonary bypass. The patient remained normal thermic and with the heart beating, an incision was made in the main pulmonary artery and carried across the pulmonary annulus into the right ventricular outflow tract. The pulmonary valve was not resected. A portion of pericardium was tailored to the size of the outflow tract and sewn in place using a running 6-0 Prolene suture. Care was taken not to catch the valve leaflets in the outflow tract patching. The patient was weaned from bypass without difficulty. All cannulas were removed. Purse string sutures were tied. Heparin was reversed using Protamine. The mediastinum was copiously irrigated and drained. The sternum was approximated using stainless steel wire and the wound was closed in running layer of Vicryl and subcuticular Monocryl sutures in the skin. Sterile occlusive dressings were applied and the patient was transported to the Intensive Care Unit. The bypass time was 22 minutes.


VINCENT PARNELL, M.D.

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VP:STATS:mh

DD: 09/15/04 DT: 09/16/04